

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13338

13338

FILED APR 27 1953 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 463

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1000 Dewey Ave. Parkview Nursing Home		d. STREET ADDRESS (If rural, give location) 308 Vassar St.	
3. NAME OF DECEASED (Type or Print) Luella		4. DATE OF DEATH (Month) (Day) (Year) April 12, 1953	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH November 15, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurses aid		10b. KIND OF BUSINESS OR INDUSTRY Hospital	9. AGE (In years last birthday) 66
11a. BIRTHPLACE (City and State or Foreign Country) Platte County, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Samuel McMillan		13b. MOTHER'S MAIDEN NAME unk.	
14. NAME OF HUSBAND OR WIFE Willard B. Lott		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 498-24-8752		17. INFORMANT'S SIGNATURE OR NAME Mrs. Melvin Baird	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Arteriosclerosis Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19. DATE OF OPERATION 3-31-X	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 7-21-1951 to 4-12-53, 1953, that I last saw the deceased alive on 4-12-53, 1953 and that death occurred at 8:27 p. m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) [Signature]		23b. ADDRESS 218 North 7th Street	
23c. DATE SIGNED 4-13-53		24a. BURIAL, CREMATION, REMOVAL (Specify) burial	
24b. DATE 4/18/1953		24c. NAME OF CEMETERY OR CREMATORY Camp Ground Cemetery	
24d. LOCATION (City, town, or county) (State) Buchanan County, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS [Signature] St. Joseph, Mo.	
DATE REC'D BY LOCAL REG. April 22, 1953		REGISTRAR'S SIGNATURE 485 [Signature]	

(Licensed Embalmers' Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Eugene Wood

Licensed Embalmer No. *3804*

P. O. Address *319 So 10th St Joseph, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.